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April Holmes

Aging Together

Chris Miller

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Recommended Citation

Holmes, A., & Miller, C. (2008). The Aging Together Partnership: Collaborating to Improve Quality of Life for Older Adults. *Age in Action*, 23(4), 1-5.

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Case Study

The Aging Together Partnership: Collaborating to Improve Quality of Life for Older Adults

by April Holmes, MS Ed. and
Chris Miller, MBA

Educational Objectives

1. Demonstrate how the Aging Together experience improves services for older adults.
2. Describe the partnership structure and participation that makes this an effective model for community services amidst demographic changes.
3. Illustrate tangible service improvements resulting from Aging Together collaborations.

Background

Aging Together is a community partnership encompassing the counties of Culpeper, Fauquier, Madison, Orange, and Rappahannock. The region is a changing mix of rural land and a “bedroom” community adjacent to heavily populat-

ed Northern Virginia and has been identified as one of the fastest growing areas on the East Coast. The two northernmost counties are witnessing an influx of retirees, while the three other counties have large populations of elders who have lived there for many years.

In 2001 the partnership completed the region’s first Elder Needs Assessment through surveys of 1,035 adults ages 60 and over. Used in combination with 2000 Census data, the survey provided a picture of regional demographic changes and their implications: the numbers of adults ages 60 and over, the fastest growing segment, are expected to rise by 45% between 2001 and 2010; 27% of residents 60 and older reported a need for assistance with activities of daily living; family and friends provide 80% of needed assistance, yet the number of potential family caregivers is decreasing; 24% of older people live alone and may not have support if they experience illness or disability; and, these older adults have a strong preference for in-home supports rather than services in nursing homes or other facilities. In sum, the survey’s data indicated

a rapidly increasing need for a community-based response to assure that older persons could remain in their homes, with access to affordable transportation, housing, health-care, and other supportive services.

The Aging Together Partnership Aging Together began as an informal coalition of about 30 individuals who recognized early the emergence of a growing aging population. It was led by the Area Agency on Aging, which in this region is part of the Rappahannock Rapidan Community Services Board (CSB). The coalition sought and was awarded a development grant from the Community Partnerships for Older Adults program of the Robert Wood Johnson Foundation (RWJF) in November 2004. This program helps local partnerships create strategic plans to address priorities that have been identified through data collection and community input. The coalition, which had grown to over 100 individuals, organizations, and older adults, adopted the name Aging Together to reflect the reality that aging affects everyone and that collaboration is the best way to improve supports for seniors. In May 2006

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Aging Together received another grant from the RWJF to implement the strategic plan. These resources, funds, and technical assistance helped the partnership coordinate the needed activities to put the plan into action.

Structure. The structure of the Aging Together partnership is central to its success, for it employs a combination of county teams and regional workgroups that assures relevance and grassroots “buy-in,” as well as an overall leadership group that provides “top-down” commitment. In our planning district each county prides itself on its individual character. The first step in developing the partnership was to assure that each county’s needs would be recognized and addressed by building on existing county teams. Each of these teams has its own vision, tied to the overreaching partnership vision, and works at the grassroots level to address local needs. County teams are partnerships in themselves, whose members include older adults, service agencies, faith-based groups, governments, and advocates., Acknowledging that some issues are too broad to address locally, regional workgroups collaborate across agencies and counties on issues affecting the entire area, including Caregiver Education and Support, Medication Access, Health and Wellness, Adult Day Healthcare, and Workforce Development . A small staff provides support to the county teams, regional workgroups, and individual members. The Core Leadership Group guides the Aging Together partnership. Its composition has been strong from the start, for all members of the Core Leadership are either agency

directors, department managers or other influential members of their communities. Modeling the collaborative approach of Aging Together, Core Leadership members establish credibility for the partnership in each county and have linked the partnership to local agencies, citizens, government, and business resources.

Partners. Aging Together’s partners reflect the spectrum of individuals and groups. They include area hospitals, health and long-term care organizations, social services departments, local governments, older adults, schools, disability-related organizations, faith communities, Health Departments, Cooperative Extension Services, the AARP, Triad, family caregivers, housing agencies, legal services, law enforcement, civic organizations, and transportation providers. The diversity of the membership reflects Aging Together’s inclusive and comprehensive response to building a community which values and supports its older citizens. Central to local collaboration are County Resource Specialists, based in member offices in each locality, who maintain information on local resources, conduct outreach for partnership initiatives, and support the local teams in carrying out their workplans.

Strategic Vision and Goals

Starting with information from the Elder Needs Assessment, Aging Together developed its vision and strategic plan with full community input. Aging Together stays connected to the opinions of older persons through Community Conversations on Aging. These public

forums are held annually in each county for older adults and the community at large. The first Community Conversations established our vision and strategic goals: *Our vision for aging is that citizens living in the region retain their sense of place and community, serve and contribute to that community and are assured of help when needed from family, friends, neighbors and places of worship, as well as from helping organizations and a responsive government. All seniors are valued and are able to move smoothly through a continuum of care in a manner reflective of their individual needs and preferences.*

Our strategic goals are to: Facilitate expansion of long-term care and supportive services; Establish an effective and sustainable volunteer network; Increase the capacity of the local paid and informal long-term care workforce; Increase awareness of the importance of healthy lifestyle among seniors; Increase knowledge among older adults and caregivers about long-term care options; and, Assure vitality and sustainability of county/regional partnerships.

As our area’s only time when the community fully focuses on the needs and interests of seniors, Community Conversations have asked for specific comments on issues such as transportation, housing, volunteerism, and caregiver supports. This year the Conversations focused on acknowledging the gifts and values seniors give to our communities and challenged us to find ways to use these resources better.

Results of This Collaboration.

Through our structure, partners, vision, and strategic objectives, Aging Together has achieved results that improve the lives of older adults and their families. Some successes include: a) more than \$1.5 million in new resources has been generated across the region; b) a new regional adult day health care program opened in 2007 through collaboration involving the Area Agency on Aging/Community Services Board (CSB), Culpeper Human Services, the Virginia Department for the Aging, and the Alzheimer's Association; c) with technical assistance from Aging Together in developing the proposal, the CSB was able to gain funds from the Virginia Healthcare Foundation for a Rappahannock Rapidan Medication Assistance Program; d) regional transportation planning, using the Aging Together structure as a model, brought together public and private transportation providers, local government, human services providers, and area transportation consumers to create a regional plan. Aging Together's part in this plan is coordinating volunteer transportation networks. One outstanding example of such a network is Fauquier County Volunteer Transportation Program, or VolTran, organized through the efforts of the Aging Together team in Fauquier County; e) Aging Together is teaming with Legal Services this fall to provide training for local attorneys on elder law; f) the partnership is working with adult service workers, first responders, and the domestic violence network to develop continuing education to assure coordinated community responses to abuse and neglect; g) the Caregiver Support Workgroup

has created a template of caregiver training that has been adapted by the local county teams, resulting in the training of more than 100 family caregivers; h) in collaboration with the local community college, Aging Together sponsors training of healthcare front line staff; and, i) we have had several initiatives to improve elders' access to information and available resources; as examples, through Aging Together, the Area Agency on Aging was chosen as one of the No Wrong Door pilot sites; the Aging Together staff and team members conduct outreach to build the SeniorNavigator database with local resources to make it a viable tool; and in April 2008 Aging Together sponsored a regional campaign to build awareness of volunteerism in which over 200 people gathered information about specific volunteer opportunities. We continue to consult with local governments regarding aging issues and to assure that the needs of older citizens are built into each county's comprehensive plans.

A New Way of Doing Business

Even with our successes, there are still several on-going challenges. How does Aging Together communicate a sense of urgency, leading to policy change and recognition of community-based long term care as a priority for planning and funding? How can the community translate information about demographic shifts into concrete, manageable action plans without feeling overwhelmed or burdened? How do we maintain energy, focus, and communication within each county and across the region? These are issues into which our young partnership is just beginning to delve. Having

established a structure and networks of communication, we have a strong foundation from which to work. The partnership model has highlighted a new way of doing business with real successes to illustrate its effectiveness.

Individuals and organizations regularly pool resources to accomplish what was impossible for one single group. They also use the power that can be generated when speaking with one voice. Government and service organizations feel less overwhelmed, no longer the sole source providing for the needs of this growing demographic. For instance, individual counties spent years attempting to create adult day healthcare programs in their communities; but it was not until a regional collaboration was formed that the capacity for this service more than doubled. Aging Together provides a neutral space for testing ideas and initiatives, and for technical support and assistance to locate funding or other resources to help make them realities. The special contribution of the Aging Together partnership is not so much in providing direct services as in helping make it possible for partnered organizations to build and improve programs, all the more important in times of tight budgets and fiscal constraints.

Case Studies

Case Study #1. Mrs. M is 63 years old and has diagnosed angina, high blood pressure, and high cholesterol. Her husband's employer-provided health insurance coverage was terminated when he was unable to return to work after a motorcycle accident. Since Mrs. M had been

insured under that policy, she lost her coverage as well. She stopped taking her medications once she couldn't pay for them. Within two months she was hospitalized for chest pains and her injured husband was left without a caregiver. She had neglected her own health in order to take care of her husband and now both were in danger. Fortunately, she was hospitalized in time, went home with needed medications, and connected with **Rappahannock Rapidan Medication Assistance Program (RRMAP)** at the Area Agency on Aging. Through this program and collaboration with her physician, Mrs. M was able to get the medicines she needed at no cost. Now she takes her medications regularly and RRMAP keeps track of her refill information so she does not run out. Luckily, her heart was not damaged. After a short recovery period, she is back to her normal routine as homemaker and caregiver.

Case Study #2. Mr. L, an 83 year old widower, was paralyzed and has short-term memory impairment as a result of a stroke. On a daily basis he needs someone to fix his meals, help him out of bed, dress, and remind him to take his medicine. While Mr. L's adult children do share the responsibility of helping with his care, all are working full time; so arranging time to spend with him is a challenge. For a while they hired a certified nurse assistant to help, but concerns remained about his lack of stimulation. Often they found their father just staring at TV. When they learned about the new **DayBreak Regional Adult Day Healthcare Center**, they enrolled their father. Now Mr. L spends three full days at

the center, participating in games and craft projects, socializing, and taking outings to places like orchards and local restaurants. His demeanor has changed noticeably since he began attending, being much more lively and engaged. His children are, of course, delighted that he is involved in something he enjoys so much.

Case Study #3. Mrs. S is a Fauquier County widow who volunteers in the community by knitting caps for premature babies at the hospital. When she became no longer able to drive, she contacted VolTran to help her deliver the knitted caps to the hospital. It worked out very well for her, and she is now also using VolTran to get to her medical appointments, as well. Sometimes Mary, her regular driver, will go above and beyond to take Mrs. S to Arlington National cemetery where she visits her husband's grave. "It seems help is always available when absolutely necessary, for which I am grateful," Mrs. S said. "Mary is a willing and gracious person."

How Our Approach Can Work in Your Community

First, begin building a partnership by finding naturally occurring councils, coalitions, communities, and neighborhoods. Build on their interests, identity and strengths. Think outside the norm; do not overlook less traditional partners or unorthodox means of contacting them. Use current members, for they often make the least "typical" outreach. Second, gather information about the current and future numbers and needs of older adults in your area. The US Census can

provide valuable, free data even when a formal needs assessment is not feasible. This information will be essential to making a case for collaboration starting today. Third, develop a way to solicit community participation and feedback, so your efforts remain relevant to the people most affected. Keep partners at the table by assuring their interests are recognized and, when possible, addressed. Fourth, provide templates, such as sample work plans and curriculum, to stimulate planning, especially in the beginning stages. Fifth, keep expanding; the secret to success is broad participation. Sixth, celebrate. Share successes internally and externally. Learn how to be savvy about media and public relations. Positive relationships with media contacts can do much to help you gain broad support. Finally, build your partnership's value in the community by promoting its collective expertise on aging-related issues. Promotion and publicity renew the cycle of drawing in new partners and expanding focus and resources.

Study Questions

1. What does the Aging Together experience suggest about ways to organize collaborative partnerships?
2. What steps and elements are necessary to plan and implement system-wide service enhancements for older adults and their families?
3. How can this model be adapted elsewhere?

References

For more information about Aging Together and other community partnerships working to improve long term care and supportive services

for older adults, visit:

www.agingtogether.org

www.partnershipsforolderadults.org

About the Authors



Chris Miller has been the Project Manager of the Aging Together partnership since January 2007. Her professional background

includes providing community-based residential supports in Ohio and Virginia. Just prior to joining Aging Together, she was the Quality Improvement Director for the Arc of the Piedmont in Charlottesville. Ms. Miller earned her BS in Psychology from Mary Washington College and an MBA from Averett University.



April Holmes has been the Aging Together Communications Coordinator since August 2006. Previously,

she coordinated aging and disability-related initiatives, most recently the *2020 Community Plan on Aging and Long-Term Care Partners Acting Together for Health* for the Jefferson Area Board for Aging (JABA) in Charlottesville. She has a BA from the State University of New York at Stony Brook and a MS Ed from the State University College at Buffalo.